		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040493

Facility Name: Fairmont Care Centre

Address: 5061 North Pulaski Road (Number) Chicago (City) 60630 (Zip Code)

County: Cook

Telephone Number: (773) 604-8112 **Fax #** (773) 604-8113

HFS ID Number: 36-3980966

Date of Initial License for Current Owners: 11th May 1995

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2005 to 31-Dec-2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 31st March 2006 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,467	3,179	5,360	23,006	8
9	SNF/PED					9
10	ICF	30,074	2,768	18	32,860	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,541	5,947	5,378	55,866	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.96%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11th May 1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11th May 1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 104 and days of care provided 5,360

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	421,574	55,809	13,691	491,074		491,074		491,074			1
2	Food Purchase		292,699		292,699	(20,663)	272,036	(288)	271,748			2
3	Housekeeping	276,816	39,561		316,377		316,377		316,377			3
4	Laundry	80,697	35,312		116,009		116,009		116,009			4
5	Heat and Other Utilities			289,180	289,180		289,180		289,180			5
6	Maintenance	65,575	26,698	243,739	336,012		336,012	(3,877)	332,135			6
7	Other (specify):*											7
8	TOTAL General Services	844,662	450,079	546,610	1,841,351	(20,663)	1,820,688	(4,165)	1,816,523			8
	B. Health Care and Programs											
9	Medical Director			37,300	37,300		37,300		37,300			9
10	Nursing and Medical Records	2,612,598	297,088	260,147	3,169,833		3,169,833		3,169,833			10
10a	Therapy			2,934	2,934		2,934		2,934			10a
11	Activities	181,876	15,836		197,712		197,712		197,712			11
12	Social Services	94,024		2,372	96,396		96,396		96,396			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* *Dental Service**			440	440		440		440			15
16	TOTAL Health Care and Programs	2,888,498	312,924	303,193	3,504,615		3,504,615		3,504,615			16
	C. General Administration											
17	Administrative	62,793		280,896	343,689		343,689	(198,277)	145,412			17
18	Directors Fees											18
19	Professional Services			35,713	35,713		35,713	17,077	52,790			19
20	Dues, Fees, Subscriptions & Promotions			36,952	36,952		36,952	(26,614)	10,338			20
21	Clerical & General Office Expenses	130,844	60,621	49,904	241,369		241,369	56,894	298,263			21
22	Employee Benefits & Payroll Taxes			606,846	606,846	20,663	627,509	51,797	679,306			22
23	Inservice Training & Education			220	220		220	1,139	1,359			23
24	Travel and Seminar			2,075	2,075		2,075	4,893	6,968			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,082	10,082		10,082		10,082			26
27	Other (specify):* *Payroll Taxes (Sch.VII)**							14,718	14,718			27
28	TOTAL General Administration	193,637	60,621	1,022,688	1,276,946	20,663	1,297,609	(78,373)	1,219,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,926,797	823,624	1,872,491	6,622,912		6,622,912	(82,538)	6,540,374			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairmont Care Centre #0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			70,617	70,617		70,617	406,889	477,506			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,805	13,805		13,805	785,235	799,040			32
33	Real Estate Taxes			183,055	183,055		183,055		183,055			33
34	Rent-Facility & Grounds			1,920,000	1,920,000		1,920,000	(1,920,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,187,477	2,187,477		2,187,477	(727,876)	1,459,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		247,559	333,736	581,295		581,295		581,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		247,559	430,096	677,655		677,655		677,655			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,926,797	1,071,183	4,490,064	9,488,044		9,488,044	(810,414)	8,677,630			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	248,636	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(288)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(4,608)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,442)	24		19
20	Contributions	(600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,307)	21		24
25	Fund Raising, Advertising and Promotional	(50,769)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,997)	20		28
29	Other-Attach Schedule Per Page 5A attached	(3,877)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 152,748		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(963,162)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (963,162)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (810,414)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 1-Jan-2005

Ending: 31-Dec-2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2005)	$ (7,519)	6	1
2	Deferred Maintenance Cost (allocated for 2005)	3,642	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,877)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Fairmont Care Centre **# 0040493** **Report Period Beginning: 1-Jan-2005** **Ending: 31-Dec-2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(288)	0	0	0	0	0	0	0	0	0	0	(288)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,877)	0	0	0	0	0	0	0	0	0	0	(3,877)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,165)	0	0	0	0	0	0	0	0	0	0	(4,165)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(198,277)	0	0	0	0	0	0	0	0	0	(198,277)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,077	0	0	0	0	0	0	0	0	0	17,077	19
20	Fees, Subscriptions & Promotions	(53,366)	26,752	0	0	0	0	0	0	0	0	0	(26,614)	20
21	Clerical & General Office Expenses	(31,307)	82,201	6,000	0	0	0	0	0	0	0	0	56,894	21
22	Employee Benefits & Payroll Taxes	0	51,797	0	0	0	0	0	0	0	0	0	51,797	22
23	Inservice Training & Education	0	1,139	0	0	0	0	0	0	0	0	0	1,139	23
24	Travel and Seminar	(2,442)	7,335	0	0	0	0	0	0	0	0	0	4,893	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	14,718	0	0	0	0	0	0	0	0	0	14,718	27
28	**TOTAL General Administration**	(87,115)	2,742	6,000	0	0	0	0	0	0	0	0	(78,373)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(91,280)	2,742	6,000	0	0	0	0	0	0	0	0	(82,538)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	244,028	530	162,331	0	0	0	0	0	0	0	0	406,889	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	36,472	748,763	0	0	0	0	0	0	0	0	785,235	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,920,000)	0	0	0	0	0	0	0	0	(1,920,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	244,028	37,002	(1,008,906)	0	0	0	0	0	0	0	0	(727,876)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	152,748	39,744	(1,002,906)	0	0	0	0	0	0	0	0	(810,414)	45

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 43,704	$ 43,704	1
2	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	14,718	14,718	2
3	V	17	Management Fee Income	280,896	Lancaster, Ltd.	100.00%		(280,896)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	17,077	17,077	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	82,201	82,201	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	51,797	51,797	6
7	V	24	Seminars & Travel		Lancaster, Ltd.	100.00%	7,335	7,335	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	38,915	38,915	8
9	V	20	Marketing and Fees		Lancaster, Ltd.	100.00%	25,481	25,481	9
10	V	32	Interest	4,269	Lancaster, Ltd.	100.00%	40,741	36,472	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	530	530	11
12	V	20	Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,271	1,271	12
13	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	1,139	1,139	13
14	Total			$ 285,165			$ 324,909	$ * 39,744	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 1,920,000	Fairmont Property, LLC		$	$ (1,920,000)	15
16	V	32	Interest	51,237	Fairmont Property, LLC		800,000	748,763	16
17	V	30	Depreciation		Fairmont Property, LLC		162,331	162,331	17
18	V	21	State Replacement tax		Fairmont Property, LLC		6,000	6,000	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,971,237			$ 968,331	$ * (1,002,906)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Laurence Zung	Executive Officer	Administrative	42.5%	see attached	2	4.17%	Lancaster	$ 8,750	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	10.00%	see attached	5	10.42%	Lancaster	17,477	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	5.00%	see attached	5	10.42%	Lancaster	17,477	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,704		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: -Dec-2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)604-4416
Fax Number: (773)478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 210,000	$ 210,000	2	$ 8,750	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		2	398	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	5	17,477	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		5	931	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	5	17,477	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		5	931	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		280,896	17,077	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	280,896	82,201	14
15	22	Employee Benefits	Management Fees	2,140,820	7	394,769		280,896	51,797	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		280,896	7,335	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	280,896	38,915	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	280,896	25,481	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		280,896	(960)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		280,896	530	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		280,896	1,271	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		280,896	12,458	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		280,896	1,139	23
24	32	*Direct Interest*							41,701	24
25	TOTALS					$ 2,381,147	$ 1,575,768		$ 324,909	25

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Harston Investments		X	Long Term Loan			$	$			$ 800,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	JP Morgan Chase Bank		X	Working Capital							(960)	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 799,040	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 799,040	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 179,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 179,455	2
3. Under or (over) accrual (line 2 minus line 1).		$ (445)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 183,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 183,055	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	180,668	8
	2001	185,366	9
	2002	187,445	10
	2003	176,350	11
	2004	179,455	12

** Accrual is based on 2004 Taxes, adjusted for inflation**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040493

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-009-0000	Long-Term Healthcare	$ 179,455.00	$ 179,455.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 179,455.00	$ 179,455.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility	218,869	1995	$ 685,000	1
2					2
3	TOTALS	218,869		$ 685,000	3

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1995		$ 2,240,980	$ 57,462	20	$ 57,462	$	$ 1,041,883	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Canopy and Awning			1995	3,300	85	20	85		1,520	9
10	Intercom System			1995	1,844	47	20	47		819	10
11	Roof Exhausters			1996	2,136	55	20	55		841	11
12	Permanent Signage			1997	16,625	982	15	982		11,536	12
13	Fire Alarm			1997	68,600	1,759	20	1,759		23,285	13
14	Parking Lot Excavation			1997	45,000	2,657	15	2,657		31,596	14
15	Parking Lot Asphalt			1997	68,000	4,015	15	4,015		29,895	15
16	Concrete Curbs			1997	18,000	1,063	15	1,063		7,914	16
17	Phase I Expansion-Landscaping			1997	41,000	2,421	15	2,421		18,026	17
18	Site Sewer			1997	28,500	1,683	15	1,683		12,530	18
19	Phase I Expansion-Building			1997	1,218,394	27,835	20	108,562	80,727	693,158	19
20	Ceramic Tiled Hallway			1998	10,603	272	15	272		3,289	20
21	Electrical Enhancements			1998	6,210	159	15	159		1,926	21
22	Phase II-Landscape			1999	15,000	886	15	886		7,472	22
23	Site Sewer			1999	40,376	2,384	15	2,384		20,111	23
24	Fire Protection			1999	43,440	1,114	20	1,114		7,009	24
25	Excavation			1999	49,650	2,932	15	2,932		24,732	25
26	Phase II Expansion			1999	2,281,933	55,008	20	214,541	159,533	994,690	26
27	Electrical-Courtyard			2001	6,520	167	15	167		828	27
28	Building Roofing			2001	21,919	562	20	562		2,365	28
29	Garage Roofing			2001	7,500	192	20	192		808	29
30	Heating System			2001	17,965	461	15	461		1,940	30
31	Addition to Heating System			2002	8,561	998	20	856	(142)	2,782	31
32	Improvement to Heating System			2002	11,688	1,363	20	1,169	(194)	3,701	32
33	Parking Lot Expansion			2002	31,500	1,698	20	3,150	1,452	9,975	33
34	Garden Pond			2003	5,000	214	20	333	119	833	34
35	Installation of Boiler & Heating Pipes			2003	54,886	1,407	20	4,573	3,166	10,290	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,365,130	$ 169,881		$ 414,542	$ 244,661	$ 2,965,754	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 661,105	$ 51,043	$ 56,256	$ 5,213	5	$ 200,468	71
72	Current Year Purchases	21,522	4,304	2,649	(1,655)	5	2,649	72
73	Fully Depreciated Assets	985,445	3,112	3,529	417		985,445	73
74	**Lancaster Allocation**		530	530			5,711	74
75	TOTALS	$ 1,668,072	$ 58,989	$ 62,964	$ 3,975		$ 1,194,273	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,718,202	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 228,870	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 477,506	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 248,636	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,160,027	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental Property	$ 179,744	$ 4,608	$ 48,910	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 179,744	$ 4,608	$ 48,910	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***Fairmont Property, LLC (a related entity)***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 120,956	$		$ 120,956	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,559			15,559	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			197,221			197,221	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				186,203		186,203	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**Medical Supplies**	39-2					24,485		24,485	13
	Other (specify): **Specialty Beds**	39-2					36,871		36,871	
14	TOTAL			$		$ 333,736	$ 247,559		$ 581,295	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,706	$ 2,706	1
2	Cash-Patient Deposits	73,713	73,713	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,820,201	1,820,201	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,072	47,072	6
7	Other Prepaid Expenses	695	695	7
8	Accounts Receivable (owners or related parties)	12,117	660,753	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,956,504	$ 2,605,140	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,000	13
14	Buildings, at Historical Cost		2,420,724	14
15	Leasehold Improvements, at Historical Cost	568,937	3,854,849	15
16	Equipment, at Historical Cost	1,277,062	1,405,248	16
17	Accumulated Depreciation (book methods)	(1,464,968)	(2,548,991)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction in Progress**		74,229	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 381,031	$ 5,891,059	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,337,535	$ 8,496,199	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 204,769	$ 204,769	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	73,713	73,713	28
29	Short-Term Notes Payable	708,629	465,042	29
30	Accrued Salaries Payable	450,884	450,884	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,993	15,993	31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,500	183,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,637,488	$ 1,393,901	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,637,488	$ 9,393,901	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 700,047	$ (897,702)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,337,535	$ 8,496,199	48

***(See instructions.)**

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 995,268	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 995,268	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(295,221)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (295,221)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 700,047	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ (605,386)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (605,386)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	707,684	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (292,316)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (897,702)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,322,257	1
2	Discounts and Allowances for all Levels	(1,372,504)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,949,753	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	801,457	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 801,457	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	151,592	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,895	19
20	Radiology and X-Ray	8,845	20
21	Other Medical Services	77,863	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 243,195	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Rental Income (Refer pg 23A)	198,418	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 198,418	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,192,823	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,841,351	31
32	Health Care	3,504,615	32
33	General Administration	1,276,946	33
	B. Capital Expense		
34	Ownership	2,187,477	34
	C. Ancillary Expense		
35	Special Cost Centers	581,295	35
36	Provider Participation Fee	96,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,488,044	40
41	**Income before Income Taxes (line 30 minus line 40)****	(295,221)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (295,221)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. **Cash Basis Taxpaye**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,917	2,230	$ 88,126	$ 39.52	1
2	Assistant Director of Nursing	4,333	4,621	117,053	25.33	2
3	Registered Nurses	35,331	37,563	1,046,762	27.87	3
4	Licensed Practical Nurses	3,061	3,103	77,176	24.87	4
5	CNAs & Orderlies	110,679	118,814	1,241,209	10.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,405	15,961	181,876	11.40	10
11	Social Service Workers	6,074	6,605	94,024	14.24	11
12	Dietician					12
13	Food Service Supervisor	1,373	1,478	25,871	17.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,334	36,697	395,703	10.78	15
16	Dishwashers					16
17	Maintenance Workers	3,953	4,171	65,575	15.72	17
18	Housekeepers	26,333	28,447	276,816	9.73	18
19	Laundry	8,246	8,776	80,697	9.20	19
20	Administrator	1,261	1,534	62,793	40.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,554	9,235	130,844	14.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,968	2,166	42,272	19.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	261,822	281,401	$ 3,926,797 *	$ 13.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	352	$ 13,691	1-3	35
36	Medical Director	1,170	37,300	9-3	36
37	Medical Records Consultant	117	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	115	3,287	10-3	39
40	Physical Therapy Consultant	13	371	10a-3	40
41	Occupational Therapy Consultant	17	563	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	58	2,000	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	65	2,372	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,907	$ 63,808		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,733	$ 223,757	10-3	50
51	Licensed Practical Nurses	1,162	28,879	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,895	$ 252,636		53

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William H. Pfeiffer (uptil 6/17/05)	Administrator	N/A	$ 44,903
Nenita Angelio (eff. 10/17/05)	Administrator	N/A	17,890
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,793

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 280,896
TOTAL (agree to Schedule V, line 17, col. 3)	$ 280,896
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 6,226
Accu-Med Services Inc	Data Processing	3,000
E-Health Data Solutions,LLC	Data Processing	3,118
Richard Peelo & Associates	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	2,710
Personnel Planners, Inc.	Payroll Tax Consultant	1,670
Stone, Pogrund & Korey	Legal	15,190
Cynthia R. Farenga	Legal	795
Patricia K. Hogan	Legal	754
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 35,713

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,659
Unemployment Compensation Insurance	38,922
FICA Taxes	291,900
Employee Health Insurance	137,533
Employee Meals	20,663
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	14,691
Uniform Allowance	878
Retirement Plan Contribution	8,175
Dental Insurance	10,690
Employment Fees	39,398
Lancaster Allocation	51,797
TOTAL (agree to Schedule V, line 22, col.8)	$ 679,306

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,211
Health Care Worker Background Check	250
(Indicate # of checks performed 16)	
Licenses & Fees	3,910
Promotional Advertising	27,834
Dues & Subscriptions	147
Charitable Contributions	600
Lancaster Allocation	26,752
Less: Public Relations Expense	(25,288)
Non-allowable advertising	(26,081)
Yellow page advertising	(1,997)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,338

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	132
Seminar Expense	1,943
Lancaster Allocation	7,335
Entertainment Expense	(2,442)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,968

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting and Decorating	Jan-00	$ 4,221	3	$ 1,407	$ 704	$	$	$	$	$	$	$
2	Painting and Decorating	Feb-00	10,169	3	3,390	1,695							
3	Painting and Decorating	Mar-00	606	3	202	101							
4	Painting and Decorating	Apr-00	2,192	3	730	366							
5	Painting and Decorating	Jul-00	241	3	80	41							
6	Painting and Decorating	Aug-00	592	3	198	98							
7	Painting and Decorating	Sep-00	2,588	3	863	431							
8	Painting and Decorating	Oct-00	8,123	3	2,707	1,355							
9	Painting and Decorating	Jul-02	4,909	3	819	1,636	1,636	818					
10	Painting and Decorating	Feb-04	2,742	3			457	914	914	457			
11	Painting and Decorating	Sep-04	1,973	3			329	657	657	330			
12	Painting and Decorating	May-05	3,784	3				631	1,261	1,261	631		
13	Painting and Decorating	Aug-05	3,735	3				622	1,245	1,245	623		
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 45,875		$ 10,396	$ 6,427	$ 2,422	$ 3,642	$ 4,077	$ 3,293	$ 1,254	$	$

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,017** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,360**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes (Refer pg 23A)** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,663** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRMONT CARE CENTRE, INC
Provider # 0040493
Report Period : January 1st., 2005 through December 31st. 2005.

Fairmont Care Centre, Inc. has rental property. Management was very strict in the accounting of this rental property. Maintenance workers have maintained detailed logs as to the exact hours that they have spent doing work at the rental property. The following represents a detail of the $ 198,418 of rental income as listed on page 19, line # 28 of the 2005 cost report :

Rental Income received		$227,358
Less :	Maintenance Salary & Employee Benefits	(7,318)
	Utilities	(5,759)
	Maintenance Supplies and Expense	(9,347)
	Furnishings and Improvements	(4,094)
	Insurance	(2,422)
	NET RENTAL INCOME	$198,418

*** This agrees with Page 19, Line 28.**